

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS JAN 25 1960

**-60-004671**

Registration District No. 324 Primary Registration District No. 307D Registrar's No. 8 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Saline</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Length of stay in 1b <b>3 hours</b>		c. CITY OR TOWN <b>Marshall Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1010 S Olson Street</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5 M NW Marshall</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>DRISKELL</b> Last			4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-11-1889</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen/ Farming</b>		11. BIRTHPLACE (City and state or country) <b>Saline Co, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Greenberry Driskell</b>		13b. MOTHER'S MAIDEN NAME <b>Eveline Tevis</b>		14. NAME OF HUSBAND OR WIFE <b>Anna Driskell (dec)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>499-40-3786</b>		17. INFORMANT Address <b>John E. Driskell R3 Marshall, Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____		Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>6-1-59</u> to <u>1-19-60</u> and last saw <sup>her</sup> him alive on <u>1-19-60</u> Death occurred at <u>3:00 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>James A. Reed MD</i>			22b. ADDRESS <b>Marshall, Missouri</b>			22c. DATE SIGNED <b>1-20-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-22-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Marshall, Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Sweeney-Reser Funeral Home Marshall</b>				25. DATE RECD. BY LOCAL REG. <b>1-21-60</b>		26. REGISTRAR'S SIGNATURE <i>Carl A. Reed</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Jack W. Reese

Licensed Embalmer No. 464

P. O. Address Marshall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.